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December 8, 2003

Credentials

Company Name
ATTN:
Street Address
City, State Zip Code

Dear Sir/ Madam:

Enclosed you will find an application packet in the specialty of _____ for General Leonard Wood Army Community Hospital, Ft Leonard Wood, Missouri.

Please have the applicant complete items 6A-L on DA Form 5440A-R **ONLY**. Sign the consent to release information form (USA MEDDAC FL 224). **INITIAL** to the left of the privileges requested on DA Form 5440-__-R, Delineation of Privileges - ___ and sign the top of the form (in the "requested by" block) and date. Complete DA Form 5754-R (**initialing** the answers in blocks 3-15). Sign and date the memorandum requesting clinical privileges.

In addition to completing these forms the following documents must be submitted:

a. Submit a current chronological curriculum vitae/resume. This CV must cover all periods of time subsequent to obtaining the initial qualifying degree to the present time. Please explain any breaks in time during professional education, post graduate training or hospital assignments.

b. Submit copies of documents of degree, ECFMG (if applicable), any postgraduate training certificates, board certification (if applicable), and current licenses for all states in which the applicant is currently licensed. Also submit a list of all non-current licenses ever held with an explanation of any that have ever been subject to disciplinary action. These licenses **must** be prime-sourced verified.

c. Submit CME certificates for the past three years.

d. Submit a current copy of the Basic Life Support (**mandatory**) and any Other certification cards held.

e. The name and address of the hospital(s) where currently holding clinical privileges.

f. A copy of the mal-practice insurance certificate (if applicable).

g. Our committee requires at least two letters of reference. The letters are normally from supervisors but can be from a peer, if the peer has first hand knowledge of clinical practice. If holding privileges at a hospital, one of the letters must come from the Chief of Staff of the hospital, the clinic administrator, the professional supervisor, or the department head from the hospital. These letters should cover the areas of clinical practice, rapport with patients/peers, etc. The letters must be mailed directly to our hospital by the author on company letterhead.

h. Submit a statement indicating the scope of current clinical practice including any civilian hospital clinical privileges. The data included should relate to the volume and type of services provided. A copy of the clinical privileges granted by the hospital would be sufficient.

If you have questions I can be reached at (573) 596-0417. **Please mail the original forms completed to:**

General Leonard Wood ACH
ATTN: MCXP-CCS-CR (Creds)
126 Missouri Ave
Ft Leonard Wood, MO 65473-8952

Sincerely,

Enclosures

Linda Nalley
Credentials Coordinator

GENERAL LEONARD WOOD ARMY COMMUNUTTY HOSPITAL
CONTRACTOR'S CHECKLIST FOR APPOINTMENT

NAME:_____SPECIALITY_____REQUEST DATE___/___/____

Start Date:___/___/____

This form must be completed by the contractor with verification dates and initials completed in the right column for all items listed below. Upon completion by the contractor, this form, all original documents, verified copies with original signatures of license(s), degrees, board certificate(s), Federal DEA Certificate, BLS, ACLS, ATLS, PALS certificates will be forwarded to Kim Russell, COTR, 126 Missouri Avenue, Fort Leonard Wood, Mo 65473.

DOCUMENTS	CONTRACTOR VERIFICATION DATE	INITIALS
INITIAL APPLICATION FOR CLINICAL PRIVILEGES (DA FORM 4691-4, JUL 89)		
a. All items in Section A – F are completed correctly.	___/___/___	_____
DELINEATION OF PRIVILEGES RECORD (DA FORM 5540A-R, JUN 91)		
a. Appropriate Category is checked in section 2.	___/___/___	_____
b. All items in Section 6 are completed correctly .	___/___/___	_____
CONSENT TO RELEASE INFORMATION/ STATEMENT OF APPLICATION (USA MEDDAC FL 224, DEC 95)	___/___/___	_____
DELINEATION OF PRIVILEGES – (DA FORM 5540-1( )-R JUL 89)		
a. All requested privileges have been initialed as appropriate and not completed with a check mark.	___/___/___	_____
MALPRACTICE AND PRIVILEGES QUESTIONNAIRE (DA FORM 5754-R, JUN 91)		
a. All items 1 through 15 are completed correctly.	___/___/___	_____
b. All items 3 through 12 have been initialed as appropriate and not completed with a check mark.	___/___/___	_____

LIST ALL THAT APPLIES

DEGREE(S)	UNIVERSITY	GRADUATION DATE	
a.		___/___/___	___/___/___ _____
b.		___/___/___	___/___/___ _____
c.		___/___/___	___/___/___ _____

INTERNSHIP(S)	UNIVERSITY		
a.		___/___/___	___/___/___ _____
b.		___/___/___	___/___/___ _____
c.		___/___/___	___/___/___ _____

RESIDENCY(IES)	UNIVERSITY		
a.		___/___/___	___/___/___ _____
b.		___/___/___	___/___/___ _____
c.		___/___/___	___/___/___ _____

FEDERAL DEA CERTIFICATE
Number_____ EXPIRATION DATE ___/___/___ ___/___/___ _____

DOCUMENTS		CONTRACTOR VERIFICATION DATE	INITIALS
STATE LICENCE(S)	Number	EXPIRATION DATE	
a.		___/___/___	___/___/___
b.		___/___/___	___/___/___
c.		___/___/___	___/___/___
d.		___/___/___	___/___/___
CURRICULUM VITAE:			___/___/___
CERTIFICATIONS:		EXPIRATION DATE	
a. BLS (mandatory)		___/___/___	___/___/___
b. ACLS		___/___/___	___/___/___
c. PALS		___/___/___	___/___/___
d. Others		___/___/___	___/___/___
SPECIALTY BOARD CERTIFICATE(S)/RECERTIFICATION		EXPIRATION DATE	
a.		___/___/___	___/___/___
b.		___/___/___	___/___/___
c.		___/___/___	___/___/___
NATIONAL PRACTIONER DATA BANK VERFICATION DATE	___/___/___		___/___/___
REFERENCE LETTER			
			___/___/___
			___/___/___

CONSENT TO RELEASE INFORMATION/STATEMENT OF APPLICATION

I, _____, hereby give my consent authorizing General Leonard Wood Army Community Hospital, its medical staff, and their representatives to consult with any and all members of the medical staff of other hospitals or institutions, to include state licensing organizations, with which I have been associated and with others who have information bearing on my professional competence, character, and ethical qualifications. I further consent to the inspection of all documents, including medical records at other hospitals, that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested as well as my moral and ethical qualifications for staff membership. I hereby release and hold harmless all individuals who submit information at the request of General Leonard Wood Army Community Hospital to facilitate the evaluation of my qualifications for staff appointment and clinical privileges from any liability for information furnished and for statements made in good faith and without malice.

I authorize the Hospital Commander, Deputy Commander for Clinical Services, and their representatives of the General Leonard Wood Army Community Hospital to furnish any information concerning my staff privileges, performance of duty, and character while on the staff of General Leonard Wood Army Community Hospital which is requested by an inquiring agency pursuant to my application for membership in that hospital/agency. I hereby release and hold harmless the Hospital Commander, Deputy Commander for Clinical Services, their representatives and the United States Government from any liability based on the release of this information.

I hereby attest that all information submitted by me in this application is true to the best of my knowledge and belief. In making this application for clinical privileges at this hospital, I acknowledge my obligation to provide continuous care and supervision of my patients, to accept committee assignments, to accept consultation assignments, and to participate in staffing the emergency area and other specialty care units.

I certify that any false or incomplete information knowingly provided on or with this application may be grounds for not employing or accessing me, or for dismissing or releasing me if I am already employed or serving.

I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information and other qualifications and for resolving any doubts about such qualifications. I understand that it is my responsibility to keep the facility informed of any information related to previously successful or currently pending challenges to any licensure or registration; and voluntary or involuntary limitations, reduction or loss of clinical privileges at another medical treatment facility. Further, involvement in professional liability actions and the outcomes thereof must be reported by me to the facility. I further acknowledge that I am familiar with the principles and standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and will cooperate with the hospital in maintaining JCAHO standards for the hospital. I also agree to conduct any practice according to high ethical traditions. I particularly agree to subject my clinical performance to, and faithfully participate in, the hospital's quality improvement programs as the same shall from time to time be in effect.

I have reviewed the Governing Body and Medical Staff Bylaws, understand them, and hereby agree to abide by them.

_____

SIGNATURE OF APPLICANT/DATE

MCXP

MEMORANDUM THUR C, _____, USA MEDDAC, Ft Leonard Wood, MO 65473-8952

C, _____, USA MEDDAC, Ft Leonard Wood, MO 65473-8952

FOR Credentials Committee, USA MEDDAC, Ft Leonard Wood, MO 65473-8952

SUBJECT: Request for Clinical Privileges and Medical Staff Appointment

1. I request appointment to the medical staff of General Leonard Wood Army community hospital and clinical privileges as specified on the enclosed DA Form 5440, Delineation of Privileges form.

2. This request is accompanied by the documents required for the credentials review for medical staff appointment and clinical privileging.

Encls
as

_____
Printed Name

_____
Signature/Date